Massachusetts Department of Public Health
Request for Access to Confidential Information

Name: _____

Address: _____

Phone # _____ Date of Birth: ___/ ___/ ___

I would like to know if the following DPH programs maintain any confidential information related to me:

Program	**Location**

If so, I request access to:
[ ] The confidential information maintained from ___/ ___/ ___ to ___/ ___/ ___
[ ] I would like to arrange to inspect my confidential information if possible.
[ ] Please copy and mail me my confidential information.
[ ] I agree to pay twenty cents ($.20) a page for photocopies, or the actual cost incurred for records not susceptible to ordinary means of reproduction, along with postage costs.

_____ ___/ ___/ ___

Your Signature or Signature of Personal Representative Date

_____
Print Name

Indicate relationship of person signing this form to the individual who is the subject of the information disclosed.
___ Person signing is the individual
___ Person signing is the Personal Representative authorized to make health care decisions for the individual. Describe the authority._____

Massachusetts Department of Public Health
Request for Access to Confidential Information

DPH Only
DPH Decision

[ ] Request Approved
[ ] Please call _____ to arrange a time to inspect.
[ ] Copies will be mailed upon receipt of _____; and mailed to:

_____

_____

Call _____ if you have any questions.

[ ] Request Denied

_____

_____

_____

By:

_____
Signature Title Date

If a you have a complaint about this response you may file a complaint with:

Privacy Office
Massachusetts Department of Public Health
250 Washington St.
Boston, MA 02108
Phone: 617-624-6083